Information Exchange Provider Directory Task Force
<mark>Draft Transcript</mark>
January 24, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Information Exchange Workgroup Provider Directory Task Force. This call is scheduled to run until 12:00 noon Eastern Time. It's a Federal Advisory Committee, so there will be opportunity at the end of the call for the public to make comment.

Let me do a quick roll call. Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Peter DeVault from Epic?

Peter DeVault – Epic Systems – Project Manager
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Egerman? Seth Foldy? Jim Golden? Dave Goetz? Hunt Blair?

Hunt Blair – OVHA – Deputy Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Steve Stack?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Walter Suarez I believe is joining late. Art Davidson? George Oestreich? Sorin Davis?

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Keith Hess? Sid Thornton?

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Lisa Robbins? JP Little? Tim Andrews?

Tim Andrews
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Kory Mertz?

Kory Mertz – NCSL – Policy Associate
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off? Okay. With that, I'll turn it over to Jonah Frohlich.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Thank you. Very good morning. Thank you for joining us today for our Provider Directory Task Force. I believe that we're going to quickly run through the agenda today. It's a fairly full agenda. We want to try to make sure that we complete on time. I think we can.

I just want to remind everyone of the framework that we are operating under. We are in the process of more or less finalizing the directory requirements and options, sort of the left-hand side of the screen. We are more or less done on the users and uses, the functions and by and large the content. What we're doing today is we're going to look at the CAQH/eHI survey that was done and look at some of the findings from their survey on provider directories to ensure that we have adequately described the content that we might recommend be included in these directories that are being created or that exist today. We're going to look a little bit more at operating requirements and then start to get into business models and so that's going to take up most of the time for our call today.

Then I think in our next call we'll actually begin to get into our recommendations, which is sort of what we've really kind of all been waiting for. So that's where we're at today. We're sort of at the tail-end of our directory requirements and options phase.

We want to give you a quick update on our timeline. Again, we're going to look at the CAQH/eHI survey. We want to finalize the additional use cases. We have one more that was mentioned that's important around public health. We want to make sure we get your thoughts on that. We want to finalize operating requirements that will be used for our recommendations and then we're going to start discussion business considerations, which may be a fairly quick conversation. Then we'll get into sort of our next steps and have our public comment.

If anyone has anything they'd like to add to the agenda or at any point interject, please feel free. There is some feeling that we might need to schedule some additional Task Force calls, kind of acknowledgement of our relatively short timeline. Those are being scheduled and if they're needed, we will use them. We'll see what we get through today, but what we have on the next slide is a proposed new timeline in the event that we need additional meetings to get through all of our recommendations.

If you go to slide five, please: Where we are today, January 24th, is finalizing the content, use cases and operating requirements and then looking at business models, review and concepts.

On this Friday, we have an Information Exchange Workgroup call. That's co-chaired by Micky Tripathi and David Lansky. We may have the opportunity there to finalize the business requirements and discuss some of the policy issues and perhaps even be given some of the recommendations.

We then have February 7th and February 11th potentially as Task Force dates to finalize policy issues and actions. Then we should be able to, by the end of February, approve recommendations, actually send recommendations to the Information Exchange Workgroup and then for March 2nd, have the Health IT Policy Committee review those recommendations.

As we did with the Entity Level Provider Directory, we may have some recommendations or the Policy Committee may make recommendations to the Standards Committee. So that will come out of our discussions today, really, I think on operating requirements and as we get into recommendations in the next couple of weeks from Policy. Any questions on the work plan? Okay. Let's move forward, please.

Before we ask Sorin to go through the excellent survey that they conducted, I just want to remind everyone of the content that was approved from previous calls so that we have context for what Sorin is going to walk through. The content that we discussed as being necessary for an individual level provider directory included basic demographic information about the providers. That includes the name, specific identifiers, whether it's a DEA, state license, an NPI or another identifier number.

We also discussed the practice and credential information, so the provider type, degree, specialty, any licenses specifically and maybe jurisdiction of where they're licensed to practice medicine. Location information, practice site and names and potentially site links to the entity level provider directory, so we might even consider having some sort of a URL or address and there could be multiple, obviously, for each provider of where they practice and the entities of which they are affiliated. Then security credentials would be basic information about security credentials, type or location for authentication. I'm not sure that we've come to consensus on that as necessary, but it's something we should definitely discuss.

That's the content, at least that we discussed in the last call. I think I want to turn it over to Sorin at this point to walk us through the CAQH/eHI survey that was conducted recently. Unless anyone has any questions, I'm going to turn it over to Sorin.

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
Thank you, Jonah. Hello, everybody. What we did, and I'm going to make a bunch of assumptions here that you folks are familiar with CAQH and the Universal Provider Datasource. Just to give you some frame of context, we started this ten years ago; launched it eight years ago to really address what was then the credentialing problems that providers were having dealing with payers, which was collection of data in a redundant fashion. So we built a system for them to be able to put their information, demographics, things of that type into a centralized system that they then controlled and could share with organizations that needed their data. Today there are 887,000, actually more probably by now, providers using this system. They own this data. They control it. They attest to their information and they're expected and do update the information even if nothing has changed, just their signatures, every 120 days. That's just a background framing for this and just about every payer in the United States today is using this and hospitals and now Medicaid agencies are starting to use it for provider enrollment.

This is not a technology per se. It's not a system. This is really content. We collect all of this information that the providers supply and it's a fairly rich data set. As a result, we've started to see HIEs looking for provided data, the content to fill their systems and to enable communications and data exchange. So we have felt that there is a great opportunity here, but one of the first questions that we've been struggling with and this group obviously has as well, has been exactly what data is necessary. What we tried to do is to get a sense from the marketplace by conducting this service as to a minimum data set that might be helpful. Obviously, this is a work in process. This Committee is reviewing it and other folks are trying to get to the same point.

So we conducted this survey back at the end of October and what you have in front of you are the results of that survey. What I want to do very briefly is just go through it. If you go to the survey background, page three, I think you'll see the details. We actually conducted this jointly with eHI. They used their sources to put the survey questions out. It was a survey monkey. We used very few questions, because we were looking for as much response as we could. We did receive 76 responders to the survey that completed it and we're committed to sharing these results. You guys are actually the first people to see them in a completed fashion like this.

We are also thinking that based on some of the results and how possibly some of the questions may have been interpreted that there may be an opportunity for us to conduct a follow-up survey. That's something that we can also discuss, because it's possible that this group may have some questions that might be worthwhile for us to frame.

Key Findings: As you can see, more than 50% of the responders represented collaborative or community HIOs/RHIOs and they identified the kind of data that is strongly desired for a directory, such as provider

specialty, NPI number, the kinds of things that are identifiers, as well as information on practice name, locations, telephone numbers, etc.

I am thinking and I know we don't have a lot of time, but I don't believe that the questions are specifically listed on the summary, so let me just take a quick look. Bear with me, because I'm on the side of the road in a car, so I'm shuffling some papers around.

Slide four continues to show sort of the highlights of what they identified. Interestingly, bullet three, where the respondents ranked health plans as the most authoritative source for data, for provider directories and individual providers were rated as the least authoritative, we actually think that that may have been the way the question was framed, because in fact, almost all health plans today get their provider data from us. Our thinking when we asked the question was really to get a sense of how important it was to have the provider in charge of providing the information. I believe the interpretation here may have been are they an easy source to get information from, which they are not. Plans would be probably the easiest, because they aggregate a lot of that data. So it's those types of issues on questions that we're still looking at right now.

We also are very interested in this notion of how do you have control of the data. Whose data is this? How is the data to be used? At CAQH we're particularly interested in that because the provider community has been very clear on their feelings about their data and they are very concerned that with all of the things that are happening now that they will somehow lose control of their data and that this data may be used in ways that they would not approve of. I believe that that debate will continue for a while, but from our perspective, our commitment to them and the reason we've been so successful is that we don't release their data without them having visibility as to who is getting it and also having the ability to say, "No, I don't want my data shared."

Moving on to slide five; that is the first question where we identified the survey responders. As you can see, 51% were community and collaborative HIOs and RHIOs.

Slide six identifies some of the other survey responder organization types. We will be able to make more granular data available if people are interested in that. The first real question is really identifying the data elements. It's, "How important are the following data elements?" I assume everybody can read it clearly. We pulled what we thought, based on discussions with a number of people, were the minimum kinds of data that would be required and I think this group has identified much of this as required. We did not ask for site links specifically—well, actually, we do have practice e-mail addresses, but we're not quite sure if that would translate to how this group is defining site links. We certainly don't have anything on the security questions that are being asked right now or under consideration. But as you can see, the basic data with the possible exception of hospital affiliations was required by most of the respondents. Their choices, as you can see, were pretty clear, either required or strongly desired, but not necessarily required.

Within UPD, we collected all of this data already, so the good news here is that this is currently available information. The real question for us is is this enough or what else is necessary.

I think if we go to the next slide, you can see to the second part of the question what additional data elements might be required. We received a variety of other types of information, some of it extremely granular and difficult to get and maintain over time. So one of the things that this Workgroup might be able to do is really zoom in on what data is really necessary. There is lots of nice-to-have data out there, but what is realistic and what is necessary will be two really important questions.

Do I need to ask—? Are there any questions or should I go through this and we'll do questions at the end, Jonah?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think you can go ahead and if anyone has any questions, they'll probably jump right in—

<u>**Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)**</u>
Just jump in. Okay. Great. Slide nine, question three, of the following sources—this is the one that I referenced earlier. This was intended to find out what would be authoritative sources. It was interesting that health plans were actually above state Medicaid agencies and above hospitals. As I said, we think this question, while that's very interesting, what we were trying to also get at is what is an authoritative source about provider data. One would argue the provider themselves would be the best source; however, I think the question, as I said, was interpreted as how accessible is this data and what are the best sources to access it. In that respect, it's pretty clear that this hierarchy is a correct one, at least we think so, because we know provider data is very difficult to get. I mean we've been fortunate, but it takes a long time to build this. As I said, it took us eight years and we've probably got about 60% to 65% of all of the licensed and practicing physicians in the U.S., so there's still a ways to go.

Additional authoritative sources identified by responders is on slide ten.

The next question, slide 11, was really one about the currency of data. That is a major issue for payers. It was one of the challenges that we've been facing over time. There is quite a bit of data that's static, certainly things like names, but a significant portion of provider data is dynamic in nature. It changes with some frequency and as a result, maintaining it is a major challenge. We wanted to get a sense from the responders how often should data be updated. Again, I think here the question could be read a different way too, which is how often can I access data or how often should a system be able to update data if it's presented with that data. Some were saying daily, as you can see, 22%. Others were saying weekly, monthly.

The way we've approached this is we've given providers an on-line system. It's available 24/7, so they can update daily, but we actually require them to come in and reattest, even if nothing has changed to their data set and we ask them to do that once every 120 days. That's three times a year. I can tell you that that can be a challenge in and of itself. Right now a little more than 80% of the providers in the database are compliant with that requirement. Others don't update that often, mostly because they don't have that many relationships, so it's difficult to create a compelling business reason for them to do it. We certainly remind them to do it all of the time, but you can't force them to do it; nevertheless, because so many of them have so many relationships that need this; as I said, more than 80% do comply with that.

So the real question here was for us what is the frequency, what would be an acceptable level of frequency of updates. Clearly, we want data when it changes. That's the ideal state, but that's not particularly realistic. So I think this question may need to be refined in the future as well. What would an HIE need for data updates?

Question five is, "How important is it that providers be directly responsible for updating their data?" We were actually quite surprised at the results here as very important, since I've heard discussions about not necessarily having to have them involved in the use of third party data sources. Don't bother the physicians. Use data that we've got. Clearly, here we're seeing a very strong sense that the providers need to be involved in the process of managing and maintaining their data and updating it over time.

Slide 13 is additional comments on provider responsibility for data updates. Clearly, the responders thought that providers should be responsible and it should, in some cases, be a condition of licensure, which I find kind of interesting. That's been a raging debate at some states; that the licensing boards might be the best sources to drive and push providers to do it.

Slide 14 is control of data at the provider level, the notion of secondary uses of data in a provider directory or index. We felt this was important because we know that the number of HIEs are looking from a sustainability perspective does this data have value that could then be monetized in order to sustain the process on an ongoing basis. While the concept is, we believe, legitimate the notion of making sure that the providers understand and have some level of control for that seems to be also of great interest to a lot of people and a requirement that a majority, a clear majority felt they should have.

On question six, we also had additional comments on secondary use, some of them very interesting. I won't go through it, but I think most of you recognize these and it's going to be a raging question going forward as well, especially for those HIEs that intend to somehow use this data on a broader base to maintain sustainability over time.

Question seven, "What are the different applications that you're planning for provider directory?" Meaningful use at the very top. I think most of this is clear. The group has discussed it before and it's just useful to know. Actually, Micky is not on, but he was helpful in framing some of these questions. Question seven continued, slide 17, additional provider directory application responses. Public health did come up. We did not have it, I believe, as one of the choices, so these came in as comments and that is something that we're very interested in understanding more about too, because we believe that there is a significant opportunity there.

Slide 18, our responders by organizations: This gives you a sense of who the responders to the survey were.

I think that's the last one. I'm trying to rush through this so that we have some time for questions. Are there any questions? Is this making sense to folks?

Peter DeVault – Epic Systems – Project Manager
On question seven, two of the responses were meaningful use and interoperability. Was there a distinction between those two things?

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
I would have to get to the details, the more granular details, so if I can get back to you on that? As I said, I don't have the details in front of me. I'm in the car.

Any other questions? Is this helpful to the workgroup? Because as I said, one of the things that we're going to contemplate moving forward is sort of a follow-up survey that may get at clarifying a couple of the questions and possibly adding additional questions that might help frame our recommendations.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I certainly think this is very helpful and I would hope that we could have some input into the kinds of questions that CAQH and eHI might put into a follow-up survey. The prioritization of what's absolutely required versus nice-to-have I think is going to be important for us to distinguish and I don't think we've necessarily gotten to the essence of that in our listing of content. When you look at our slide six we just before the call mentioned the basic demographics, practice credentials, but we haven't essentially put together the list of what's absolutely necessary for what we would recommend as being a minimum set of data. I don't know if others feel that that's more a function of the Standards Committee or if it's more the Standards Committee that would recommend if there is a standard for how that data is represented.

Does anyone have any specific thoughts on that? No? Okay.

Tim Andrews
Jonah, so if I understand the question correctly, I think the minimal data set is more of a policy issue, so I think that it should be a concern of this group. I think the representational matter should be a standards concern, how they're capturing and transmitting or whatever, but I think what is the data that's required certainly seems to be a concern of this group.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes—

Hunt Blair – OVHA – Deputy Director
Yes, Jonah. I would also agree. I think that it would be important for us to be fairly specific in our recommendations for the Standards Committee or for the Policy Committee to pass on to the Standards

Committee because, as Tim indicates, I think their focus should be more on the technical standards of the policy.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay. That would seem to make sense to me. So what we can do here is I think if we take together the content from slide six and what we just heard from Sorin, if we can essentially finalize what we consider to be the minimum required set. We may need to refine this at some point in the future, but it seems that from the CAQH/eHI Survey if you go to their slide seven, which is what is it on our slide? I think it's their slide seven. What eHI and CAQH found is that in their survey everyone responded that the first and last name were absolutely required; that the provider type was, by all accounts, completely necessary; provider identifier is necessary; license number, state of issue, so state licensing number; and an NPI were deemed critical. Provider specialty and hospital affiliation I think there was less agreement that that was a minimum required data needed for collection. What do others think it would be? Is that more of a nice-to-have versus a required field?

Hunt Blair – OVHA – Deputy Director
I think that I would expand the hospital affiliation to entity affiliation and I think if we're going to have the ILPDs be able to map up to the ELPD then we've got to have that.

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
Yes. In terms of entity, in many cases I think that that's going to be the practice location, name and address of practice.

Hunt Blair – OVHA – Deputy Director
Well, I guess I just meant that this is a vexing nomenclature problem with all of this, but I mean I agree, Sorin, that we need the place where the provider practices. But then if in terms of this whole question of how they fit into the entity level directory, we had, I think on last week's call—though it all runs together— the conversation about a provider, who might be affiliated with Kaiser, might also volunteer at a free clinic, etc., might have several different roles. So that's the distinction I was trying to get at.

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
Actually, you can almost count on that. I mean we see that in our data set and it's actually one of the reports that I will be running. I probably can have results for our next call in terms of the one-too-many relationships a provider may have to practice locations and we know that there are quite a few of those out there. Usually there is a primary practice and then there are additional what we call practices, additional entities that they will be affiliated with.

It will become, I can tell you right now, a horrific mapping issue for people because while providers have their type one NPI, which seems to be fairly consistent, the entities identifying them in some easy way is a pretty big challenge. I can tell you on a data set it is one of the pieces of data that we find has the least amount of accuracy in it. Providers will often not properly identify their practice locations. They'll either misname them or attach their own name to them, so we know that that is going to be a fairly significant challenge going forward.

Hunt Blair – OVHA – Deputy Director
I completely agree with that, the nature of that challenge and significance.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
I think to your point, Hunt, we need to have a definitive mapping to the ELPDs because of all of the information that's necessary for exchange that will reside in the ELPDs, correct?

M
Yes.

Hunt Blair – OVHA – Deputy Director

I think so. I think that this is all beginning to call out for a need for more visual representation of it, because it's starting to get—maybe as we do the use cases we can think about a way to do that.

M
Yes, I—

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Well, but I mean there is mushiness in the English language version of provider locations, but there can't be any mushiness in the definition of what it takes to exchange information, the electronic address and all of that.

Hunt Blair – OVHA – Deputy Director
Right. If Paul were on the call, he would be speaking up about the machine-to-machine—

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Right.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Well, what this seems to speak to is that on the entity level side we have a very specific definition of an entity and that there is a very specific SMTP address or e-mail address or whatever that is affiliated with each one of these entities. What I'm hearing here, and I think I agree, is that for these ILPD directories we need a minimum requirement, not just the demographics and the other data that we just mentioned, but we need to be able to link each one of those to a specific ELPD entry. So there does need to be this direct affiliation and it's different from a hospital affiliation where you have privileges. This is where the provider actually practices medicine and so there needs to be that direct link between their listing in the ILPD and each one of their ELPD affiliations.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Right. If they're going to receive clinical information we need to know where that is.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Sorin, in your description there when you said that providers may mislabel their entity with which they're associated, is that a free text field? I mean if we're talking about this ELPD directory wouldn't that be something where people would be able to select from established SMTPs?

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
The challenge with that; and I can speak to it from the perspective of how we built the UPD; there is no current source for listing every possible practice that I'm aware of and if there was, presenting that to physicians to select from it would be a monumental task. It would be like handing them the phone book and asking them, "Pick your practices out of the handbook."

The way we approach it is they are responsible for filling out their applications. Often they will use practice administrators to do it. What happens is they self-identify, they self-report all of their affiliations. We ask them specifically to identify and if it helps I can walk people through the details of how providers actually are served up these questions. It's an interview style interface, that sort of thing.

What we did find when we conducted our data quality study on this was though in part it's the way we asked the question too, because we asked them the name of the practice location and how it should, "Appear in a directory." That latter part may have led to some confusion on the part of providers where they actually insert their name and then provide a practice address instead of XYZ Group Practice. So we are in the process of actually modifying that question to very explicit; that we want the corporate name of where they're practicing. We saw that we were running an error rate there of about 25% or 30% on the

sampling we did. The address was correct well over 90-plus percent of the time. It was just the name of the practice that was the problem.

I don't know if that helps, but that's—

Hunt Blair – OVHA – Deputy Director
Thank you. It does help. So this discussion that we're having is the perfect illustration of why even with the ELPDs there is still this role of state and sub-state ILPD because we're going to have to provide a service so that providers in our region don't have a limited number of ELPDs to choose from. I think we're actually finally going to have gone full circle on getting back to why at the state level there is a role in the provider directory riddle.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I would certainly agree with that. Just to finalize this content discussion, so entity association or affiliation I think we need to make sure we define what it is we're talking about appropriately for our recommendation. But it seems like we need to have a direct—we're recommending here that our necessary content is a direct link between the individual provider and the entities in which they practice, the entities with which they are directly affiliated, where they would potentially be receiving content, patient-specific content.

We also see that the name and address of the practice locations is deemed to be critical. I would certainly agree with that. In our use cases we could certainly anticipate that a provider would need to validate where it is that the patient's data, they're trying to send it to what entity and this essentially would allow for a second check of that. The practice telephone seems like a very reasonable thing to include in order to validate. Again, there is another level of validation here. If there is any uncertainty about sending patient information then the practice or the site can pick up the telephone and then call the site that they want to refer information to when a patient is there.

Does anyone disagree that the practice demographics, telephone, location, etc. is not critical or necessary here?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Jonah, I guess I'm thinking like a lawyer this morning to say I object, not to object, but just to make a placeholder for the future. I'm thinking of scenarios where we have ... physicians and that's in any number of different specialties, but I'm an emergency physician, so we have physicians in my large, multi-specialty practice that is in 46 states, who may have privileges at 15 different hospitals across 5 different states. So when we talk about practice address, practice location, things like that, certainly there is a centralized office location when you work back through this that's a hub of sorts for where that person originates. However, it really has nothing to do with their individual clinical practice at any of those 15 different hospitals across an assortment of states.

So I guess the placeholder I'd look for or suggest we put in here is just the written acknowledgement in whatever we propose that we are well aware there are circumstances that we know we are probably not accounting for at this time and there will be a need to evolve this. I guess I think when we really get into the complexity—and I think Sorin kind of alluded to this—with trying to ask the doctor to define their practice from a dropdown menu, I think that the real-life complexity of this is going to really be something of a demon when we really try to code it out in computer language that doesn't handle that uncertainty very well.

Seth Foldy – Wisconsin – State Health Officer
Yes. I think also we are, for the moment, not really discussing alternate use cases for the directory that might have public health utility and again, not knowing the scope it's hard to define the details. Let me draw out a few examples. If public health agencies are going to be listed for individuals, such as the epidemiologist in a public health jurisdiction is going to be listed as an individual under an entity that use case is going to differ greatly from the quality management use case. Similarly, if these directories will be used—and I sincerely hope they are, otherwise we end up setting up parallel structures—for urgent

alerting of clinicians about public health or other disaster events in their community that's a use case that would have to be considered separately to really understand the requirements.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes and so, Seth, I would ask that we bring this up again—we're going to be discussing the public health use case—and make sure that the content we just discussed, if we are missing anything to meet the requirements of that public health use case because specifically, sending out public health alerts is discussed in that use case. I think we want to make sure we have all of the content we need for the directory to support it, so that's a good point.

I think, Steve, I agree with you. I think the issue of admitting privileges and a provider who might have five or ten hospitals that they would admit to; in larger areas that's certainly the case; I think we need to consider, again, the use cases under which the ILPD is most critical and whether or not that actual hospital affiliation is important in the ILPD. I'm not saying it's not important substantively for healthcare delivery, but for the ILPD use case if a patient is being admitted, for example, to a hospital and being referred from a specialty clinic or a primary care practice or they walk in through the ED I have a harder time envisioning how an ILPD will be used to send information and find a physician's hospital affiliation as opposed to pushing a message to a specific hospital that that provider might practice in or pulling it from a practice if you're the hospital where the patient was at. So it's less clear to me that hospital affiliation, per se, where a specialist might practice in multiple, five or more hospitals, is as important here, but I might not simply be seeing what the appropriate use case is for it.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Well, I'm trying to conceptualize this, but it is kind of complex. Visuals might help, but I'm thinking there are at least three key things that we'd have to know for sure. One is we need to have the patient identify secured with as much as 100% reliability as possible, just so we don't have errors propagating through the healthcare system.

Then I know we've struggled here a little bit with the validation part of this or authentication, I guess, of who the people are, but I think it's reasonable that we would want to be very certain that the person requesting a transfer of information is actually authorized to do so. So I think it's essential that the directory somehow help us to make sure that the person who says I am clinician so and so requesting information from X to Y be sent, that that person actually has proper standing to make that request.

Then the third part is it may be that the clinician requesting the transfer of information might have some way to designate the landing point to where it goes. So one of those physicians I said, who may practice at 15 hospitals could be at 15 different facilities that are in different health systems and so it may be that somehow the system actually says, "Yes, Dr. Smith is appropriately authorized to request such a transfer. In this instance he's saying it should go to Sloan-Kettering Health System or something," and then that's an authorized receiver of the information. I don't think we've discussed it in this way, so I may be actually throwing in a whole different way of conceptualizing this, but the system may need the flexibility for the person requesting the transfer of information to be able to make some designation as to which location it goes to. These directories, I guess, would help to map that out.

Peter DeVault – Epic Systems – Project Manager
I'd like to address that set of comments. First of all, I agree that there needs to be some logic somewhere that makes those determinations about whether somebody is authorized to make a request or whether information should end up in certain hands, but I don't think it belongs in the ILPD or in the ELPD. To my mind, those directories really just need to serve the specific function of pointing to locations and giving addresses of entities. The logic for determining whether a particular transaction is authorized from a variety of standpoints, if we put that burden on the ILPD and the ELPD that's going to increase their scope and complexity tremendously and I'd rather see us start simple and have that logic reside in, for example, the source system that's having the data requested from.

M

Can I ask you one question on that point though? Would it be reasonable just to say that in order to even be included in the directory you have to pass some threshold? Do you know what I mean?

Peter DeVault – Epic Systems – Project Manager
That would make sense, but that's obviously very different from for a particular transaction having the knowledge about whether a patient says it's okay, etc.

M
Right.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay. Good. I think this is definitely very helpful and I want to make sure that we have a chance to move on. If you can advance the slide, we mentioned a couple of things sort of as well last week around provider identity theft and I think there's a consideration as to how "public" these identity directories are. I don't know. I certainly don't have an answer as to whether or not and how these are published and who would have access to them, but that does seem to be an important security question. I'm wondering if we want to discuss this here, because it is specifically information around content, but it's more around access to content and not content per se. So I think the question is, well, the questions that we've defined on slide eight are how should the issue of provider identity theft factor into establishing the minimum data set required to enable required functionality. How much do we actually need to provide?

Then security credentials: Members raised concerns about making security credentials discoverable in the ILPD. I'm not exactly sure what a security credential is in the ILPD. I mean I think I understand in the ELPD context, but I think I'm not quite sure I understand it in this context. I don't know if anyone has a thought on this, but—

Tim Andrews
I've thought about this quite a bit actually and dealt with it in other arenas. I think there are two issues. One is sort of the ... issues raised here, which are quite real I think and need to be addressed. This thing has to be reasonably accessible or it won't be that useful. Therefore, use of it for malevolent purposes becomes an issue. There is plenty of information in it for it to be used for bad purposes, so I think access and control over access and updates is critical. It's very much the same issue you have with DNS and DNS registrars; if that information is improperly updated all sorts of bad things happen. In this case it's much worse because information goes directly to patient care, so the first issue is just identity theft and things like that. Bad things happening to the doctors themselves, who are listed or the clinicians, providers in these directories, which they should be concerned about, because there's more than enough information to steal their regular credentials and run up credit card bills and things like that.

The secondary issue is it can play havoc with healthcare, because you can get false physician substitutions. You can imagine for various kinds of reasons that people want to do that, whether it's fraud on insurance companies, stealing drugs, all sorts of stuff. So there is a lot of issue here I think. We don't know how much it will be, but I think if this is successful it will be more of an issue. The more providers that are in it the more accessible it is, the more it gets used, the more people will be aware of its power and will attack it. So I think it's at least at a level we have to recognize it and a kind of policy level we have to at least consider what we do to present these things.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay.

Tim Andrews
There's also one last issue that's sort of related, which is accuracy, because this also relates to the accuracy. So beyond all of the sort of bad stuff that can happen, it will also fail in my opinion, as a service because if it gets modified by ... should be modifying it and it's not accurate enough we'll also lose the quality of the data. So there's that other side of the issue, which is this data needs to be fairly accurate is my understanding based on the conversations in my experience in order for it to succeed.

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
Yes. Tim, I really totally agree with you on the first concern in terms of real identity theft for somebody then setting up credit lines or what have you for the physician, the data that I think we have to capture here is already quite publicly available. It isn't that we would be creating a new source of data that isn't based on what already exists. You could go on-line and look up any provider and get their name, their specialties, their practice locations. I mean it's akin to almost advertising.

The second two points you make are the really important ones, which is that if that data is in some way inaccurate or not timely it can wreak havoc with the referrals or the exchange of information. I would be much more concerned on the latter two points than on the first point provided on the first point you're not really collecting sensitive data, like Social Security numbers or things of that type.

Tim Andrews
Well, yes and no. Again, you're right; all of this information is publicly available, but what you have to keep in mind is if it's publicly available, but kind of difficult, you have to make a lot of effort to get at it and you can't do it at scale, it's far less subject to attack. If you have one big, long list that any computer can scan looking for enough data to design attacks it may not be quite enough in the database itself. But if it's a good start and enables subsequent attacks beyond that to get the missing couple of pieces of information that might be needed it will become a target because it's much easier to get at—

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
Yes.

Tim Andrews
So yes, I understand that's true for most of it. That's true for almost anybody if you want to go through the work you can basically dig and find all of the information you want about anybody in the United States and most of the world in fact, but it's just not that easy. Once you have a big database you can set up ... that just read through it constantly and then try and find other information to match up with it. It's a more serious issue and I wouldn't under estimate it only because the providers have to cooperate and if they start getting burned that's another big issue here. If they start—

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
Oh, it's huge.

Tim Andrews
—... I put my information in there and I end up with identity theft I don't want any part of this.

Sorin Davis – CAQH – Managing Director, Universal Provider Datasource (UPD)
All it takes is one and you've— I mean we live—

Tim Andrews
I don't want to overstate it. I agree with your premise; the point, the real issues are the second two issues in terms of sort of the real damage they can cause, but I guess especially getting started I wouldn't underestimate the need to pay attention to issue number one because you're in a different medium when you have a big electronic database.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
So this is certainly helpful for me to understand the issue here. It raises, I think, a couple of policy issues that we are going to have to discuss in a subsequent call. One is around policy recommendation that specifically gets to the point of who has access to the individual level provider directory and the kind of security requirements that we would recommend and audit trails to prevent things like ID theft.

Secondarily, it sounds like we need similarly to have a policy recommendation around access control and change control so that, first of all, we have control of how the ILPD content is managed and updated. We cannot have it being updated without having strict change control policies and especially if we want to maintain the information. We may want to have some mechanism or recommend some mechanism for

those out in the field to make changes to the content of an ILPD. I'm thinking about any practice that's looking up an entry, finds one and through a process identifies that this is no longer a valid entry and so there needs to be some mechanism for that to be updated in the field that's being used. But too, I think the two policy recommendations for us to consider are around security and access and then around change control.

Tim, did I sort of understand your explanation and sort of—?

Tim Andrews
Yes. I think that's exactly right. Yes.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay. Good. Any other thoughts on content; I think we're on slide eight; before we move on to slide nine?

Slide nine, Additional Use Case Assumption: Right. Okay. So we're done with content. We're moving on to the final use case and, Seth, I think will be—

Seth Foldy – Wisconsin – State Health Officer
Unfortunately, I do have to leave the call and I was wondering when will the public health use cases next be discussed or should I deposit information on this call before I sign off?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
You know what? Let's get right into the public health use case, because I think this is when we intended to discuss it and then I'll—

(Overlapping voices)

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. Okay. Excellent. So let's go right to it. Let's go to slide ten, please. Here we go. The specific use cases around public health alert and, Tim, you helped work on this, so if I misstate anything, please chime in. Again, the framework.

The exchange need of the ILPD for the public health alert use case is that a public health agency needs to send an alert to selected providers. This could be for communicable diseases. It could be about bioterrorism drugs, etc. The public health agency has some information on individual providers, but does not have additional providers' individual location information, so it might not have their e-mail address or their SMTP or whatever their ELPD information is.

The ILPD functionality, what would it actually do? The public health agency could use the ILPD to identify individual providers and their locations. The ILPD would need to provide flexible querying capabilities to identify providers for various types of alerts. The ILPD would list potential locations of providers where it wants to send alerts, so it could potentially list all of them and then the public health agency could select. The public health institution identifies those proper locations and then using the ILPD, the digital credentials of both, the sending and receiving computers are used to validate identities when results are delivered.

I'm assuming this means that using the ILPD correlates to the ELPD with the digital credentials. Tim, I'll make sure that I'm saying that correctly. Is that right?

Tim Andrews
Yes. Well, that relates back to the question we were just discussing that Hunt raised, that we really need very good links between at least what our presumed model between the ILPD and ELPD. Right?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes.

Tim Andrews
I think we had this discussion even last call that we wouldn't be necessarily expecting credentials in the ILPD, but we'd be expecting some way to get to the credentials.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. Okay. Then in achieving exchange, that it actually gets there, the public health institution sends the alerts to providers' EHR systems. The provider's EHR system receives the alert and incorporates the EHR and the provider's EHR system ... and alerts the providers and potentially triggers additional action, so there would be a triage mechanism, as we've discussed. It gets to the front door. The EHR system, its administrator or whatever that has the ability to distribute to appropriate end points, so the providers should have access to that system.

Seth and others on our Task Force, this is the specific public health alert use case. I'm wondering if you think it's broad enough, if we've incorporated enough of the functionality ... public health in general, at least for the ILPD.

Seth Foldy – Wisconsin – State Health Officer
I apologize for not being present on the last meeting and I have noticed that this is the direction things are heading. It's a perfectly reasonable use case. I think there may be two more common use cases that need to be developed.

The first is when public health wishes to broadcast an alert to clinicians for, for example, a given jurisdiction. So the jurisdiction of Shorewood Heights Health Department wishes to notify the practitioners of the Shorewood Heights jurisdiction—in other words, they have that geographic address—that we have a problem and here is our local protocol for helping you deal with that problem. It would be to select a multiple based on geography. I believe that would be used as or more often as the individual messaging, although in the future I think public health will develop more and more capability to have one-on-one, individual relationships with clinicians, so I wouldn't discard the first use case.

If you'd like, I'm not sure when, but I could try and lay out the crude essentials of this second use case in the same format as the slide should you desire.

There is a third set of use cases, which involve when the clinician or other clinical entity is seeking to send information to the appropriate public health entity. In that sense, I saw public health agencies as having a variety of entries in the enterprise and possibly individual level directories. This, for example, might include, as we increase the automatic sending of case reports to public health. Of course, that's not shown here. Or perhaps the very conceivable short-term need to say this patient lives in this jurisdiction. Which immunization registry should I send this immunization record to; the use case in which public health is the recipient.

First of all, am I missing something that would exclude these as use cases? Can I help you get them into the pile before it's too late?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Seth, I think—and please, others correct me if I'm wrong—the third use case that you mentioned, sending a provider, sending a public health department, local, county, state or to an immunization registry some information. I believe that was covered in the ELPD use case description, where a public health immunization registry for example or even a public health department would itself be listed as an entity. Then the provider could send the specific information required to that entity. So I think that is covered in the ELPD use case.

Seth Foldy – Wisconsin – State Health Officer
And it may be less relevant to the individual entity case.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

The second ... as the first or second, but you mentioned sort of the geospatial aspect of this where you'd be able to send it to a jurisdiction or to the providers within a jurisdiction. I don't think we have covered it and the question may be whether or not—this goes back to content—there is a way for us to make a recommendation about jurisdiction in which a provider processes. Whether it's within a zip code or that the public health department has a listing of zip codes by jurisdiction that it then queries out to an ILPD. I don't know the answer to that.

Seth Foldy – Wisconsin – State Health Officer
Yes. I think and I believe the ideal would not be zip codes, since they tend to cross minor jurisdictional lines. The ideal would be the town or village or city of practice address.

Tim Andrews
Yes. In fact, at least I sort of thought that use case was covered in the use case we talked about. I mean these things are abstracted and maybe we've abstracted too much, but the whole idea of sort of needing to be able to have flexible querying capabilities was for exactly this reason, because—

Seth Foldy – Wisconsin – State Health Officer
I concur. It may be in there and I can't quite—

Tim Andrews
Yes, we may need to make it more specific, but that was certainly the first thing that came to my mind and it's, again, a technical issue but if the practice locations are in there you can query it. It will be challenging if you don't make indexes or other technical capabilities to support it, but I think you could make those pretty straightforward. I mean that's often done in these kinds of databases. I think it would be very valuable to public health to have these sorts of multi-dimensional query capabilities so you could query on different dimensions. One of the most obvious is geographical.

Seth Foldy – Wisconsin – State Health Officer
Right. So I think we could simply alter the first bullet under ILPD functionality or add a second bullet, whichever is cleanest. Public health agency uses ILPD to identify individual provider and location or select group of providers and locations by a selection criteria, but I think it's not quite reflective yet.

Tim Andrews
Yes, that makes sense.

Seth Foldy – Wisconsin – State Health Officer
Shall I leave it to you? I'm not sure who is actually doing all of the real work here, coming up with these slides, but leave it in your laps and then let you feel free to consult with me as needed?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Tim, do you have that noted or should we ask Seth just to send you a quick couple of lines?

Tim Andrews
Yes, I think I can take a crack at that. Yes.

Seth Foldy – Wisconsin – State Health Officer
Very good and I'll review back to the ELPD to see if there is any important individual need, interaction with the sending to public health use case because you may well be right that it's covered, but I have to kind of think through whether or not the entity level will be sufficient. Entity level would be able to include subdivisions, like the public health laboratory of jurisdiction X and the public health epidemiologist of jurisdiction X, right? It wouldn't—

Tim Andrews
Sure. You can have as many entity addresses as you want. You just have to—

M

Register them.

Seth Foldy – Wisconsin – State Health Officer
Abide by the policies and the rules of getting the entries in the directory, but if you have a place, an entity that is capable of conducting transactions and supporting the rules then you can have as many entries as you want in there. You can imagine government agencies and large hospitals having multiple entries in these entity directories.

Tim Andrews
I think increasingly we imagine, for examples, states might have a bus to receive many, many different kinds of messages, immunization records and electronic laboratory reports, for example. Those would then have to be sorted for their system destination and the routing of that could be a function of the message type, but it could also be a function of the directory. I don't know if this group has wisdom to shed on whether we meet and make sure that the individual level directory for such routing be part of the solution.

Seth Foldy – Wisconsin – State Health Officer
I think the way we've distinguished this—and this is where I do wish Paul was also on the line as well, because better at articulating this—is that the addressing schemas are all contained within the ELPD and the ILPD is really an association of providers to their ELPD addresses. So it kind of links where the individual provider practices to an ELPD listing, which is essentially an address. So if there's something like a public health bus then it would really be up to the bus to move that message to the appropriate address and then once it's in the four walls of that entity it's up to that entity to triage, as appropriate, where that message ends up in somebody's inbox or some system's final destination.

Tim Andrews
Yes, although I would say, having worked on these buses, the bus itself is not actually the determining factor. It's really how the entity using the bus wants to do it. In other words, they can make the bus their front door for everything if they only want to expose that one entry point. They can also expose multiple entry points all on the bus, so you can do it either way. You can have multiple addresses that all basically go physically to the same point, but sort themselves out through the directory entry rather than having some process once you're in the front door, as we call it. Or if they want they can say this is Minnesota or Florida or Massachusetts or whatever, this is our bus; you just send everything here. Then there has to be something inside the message itself that enables them to do the routing from there. You can do it either way. It's mostly a matter of preference I think and what your architectural goals are.

Seth Foldy – Wisconsin – State Health Officer
Yes. So I guess I'll try and ascertain that there's going to be an absolutely clear cut need for an individual level directory entity for public health subdomains, sub-offices and return that information to the group.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay. Thank you, Seth.

Seth Foldy – Wisconsin – State Health Officer
Thank you for accommodating my queer schedule. Thank you very much.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Sure. We're all on the same schedule I think. Any other thoughts on the public health use case before we move on to operating requirements? Good.

Let's move on to slide 11, please. We have a listing of operating requirements. What we don't actually have here is we have a listing of things that need to have operating requirements around them. We've just kind of distinguished them in three buckets. One is around data content and we've gotten into this a little bit already; that there need to be some operating requirements around how data content is accessed, updated, used, secured, managed, etc. We've already talked about potential sources in a previous conversation, but we've obviously heard from one today with Sorin from CAQH, but there are

many other potential sources, state licensing boards. I think we've heard from the Wisconsin State Licensing Board once or twice already about their methodology for updating identities, NPI and others, like health plan directories. We've heard from others as well in our Task Force and hearings. So there is certainly content out there that can be used.

What we heard in many of our Task Force meetings is that we probably shouldn't recommend that a whole new provider directory, individual provider directory be created, but that we leverage what exists. It certainly seems a very reasonable approach, but there are some other questions around data content that I think we need to consider for operating requirements, recommendations. Tim mentioned one of them, which is data validity and having sort of a minimum necessary requirement around having valid data. The less valid the data, obviously the less valuable the service and we would hit a certain level where if it's consistently incorrect then it won't be used and rendering it more or less of negative, zero value.

Another question is to whether or not there are specific content standards around data type, field and the content that would be used to populate an ILPD.

Another question around data content is whether or not for those, who are currently collecting ILPD-like data that I just mentioned previously, is there a recommendation that there be more of an effort to establish a linkage between an ELPD listing or listings and their ILPD listing in whatever database that they're currently being managed in.

So those are some of the data content issues and I'm wondering if today we want to think about other data content requirements or other policy recommendations we may want to make around operating requirements to manage data. First of all, I'll ask that question and then I'll see if there are specific recommendations you want to think about here.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Jonah, are these things that we're going to be asking the Standards Committee to define specificity in?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think in terms of a third sub-bullet, whether or not there are specific standards around data content; that might very well be a recommendation request that is made of them and maybe of others too. I don't know that the Standards Committee— I think it's more of a policy issue for us to make recommendations around things like data validity—

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Right.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
—and to make the request that the Policy Committee would at least make for the Standards Committee around—

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Okay, but if we have these different sources—not to just be too picky—but if we had these data sources we'd need them to be able to produce data in a certain standard so that it is easy— In other words, we want to push the requirement, if you will, or some translation methodology I guess. I don't know, but I mean something that requires that data come over in a way that doesn't have to be ... ILPD, right?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right. So as an example, there may be multiple ways of describing a practice location, a physical address or even a phone number. We may want the Standards Committee to come back, to recommend what the right format is and push that requirement as high up as we can to health plans and CAQH and others to ... that we have any leverage or Policy is willing to do that just so that they collect that information in a standardized way just ....

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
I'm trying to get somebody else to do the work I guess is what that amounts to, but it seems like no small task you give them to produce a number field for a phone number without dashes, right? Just to be overly simplistic.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right. Some of the other operating requirements around this that we've mentioned, do we, for example, want to start thinking about our recommendations around data content who have rights to access the content of an ILPD data content and what might that recommendation look like. Is there a recommendation here around the ability for those in the field to update and make requests to update content in an ILPD? How might that work? What are the specific policy recommendations that can be made around this in our levers? Is there something around meaningful use? Is there something around EHR certification or some other policy lever that we can think of to help make data content better in these ILPDs? These are things that we'll need to think about when we actually get to the policy recommendations.

I think the second issue that we've also been discussing is the linkage between the ILPD and ELPDs and specifically the level of integration of the ILPD and ELPD, for lack of a better word and that meaning really the association and the service. One could envision a service whereby, again, a provider or a front office staff is trying to identify where a specialist ... to refer a patient. They have an ILPD, either as a Web service for embedded in an EHR and they're able to identify the specific physician that is of interest, being able to click on that and have the direct relationship basically exist in the source system or somehow linking it to the ELPD so that workflow is very streamlined. You'd click on the ILPD. It associates with the ELPD and then the machine-to-machine communication can take place using the digital certificates of the ELPD. Is there an operating requirement here that we want to consider for those who are building are considering building these under their HIE programs or elsewhere that we recommend there be these tight linkages between ILPDs and ELPDs. This is the second operating requirement issue.

Then the third really is around security and how would security data use rights and access be managed. Again, this comes back to the previous discussion we had. I think we need to start thinking about the security requirements for identity theft and for the other issues that we've discussed as we consider our recommendations for operating requirements. I think this is really going to be we need to have a pretty refined recommendation if we want to really provide something of value to the Policy Committee.

Any other thoughts around operating requirements? Have we missed anything? Again, we're really trying to think about what it is that a state HIE and a state designated entity or another entity that is creating and managing an ILPD would need to do in order to sustain, build, develop a service that is of most value in our post-HITECH environment.

Peter DeVault – Epic Systems – Project Manager
Are you looking for additional requirements or comments on the types of requirements that are on the screen now?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Either one. If you have any specific thoughts on these—are we missing anything? Does anything here need to be modified?

Peter DeVault – Epic Systems – Project Manager
Well, the one comment that I would have on the linkages between ILPD and ELPD, I'm not exactly sure what we mean by tight linkage, but I think what we mainly need to do is make sure that ELPDs represent entities in a standardized way so that ILPDs can refer to ELPDs correctly and in a standardized way. I'm thinking that we don't need anything tighter than that, but we do need those kinds of standard representations.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay.

Hunt Blair – OVHA – Deputy Director
Jonah, I've been trying to do a drawing here and it's not anything pretty yet, but I think that there is maybe a distinction to be made between the linkage between the ILPD and the ELPD or the linkage between the ILPD and the entity, the provider entity. So in other words, we were talking earlier about an individual level provider could have multiple roles and that would tie to different provider entities. So the individual level provider directory needs to be able to account for that individual provider's different roles and then have the link through whatever the nomenclature is in the ELPD to the different provider entity. Do you see the distinction I'm making?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes.

Hunt Blair – OVHA – Deputy Director
So it just seems like there is kind of a lot that we need to tease out in that bullet there.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. Yes, I definitely agree. But I think maybe what we can do as a Task Force is when we start the recommendation piece, which is going to be our next set of calls, we start building the recommendations. It will be, I think, a lot easier to understand where we need to go once we have it on paper. So we'll take that feedback and we'll craft some recommendations.

Let's go to our final slide, which is around business model considerations. Again, this is sort of the last Chevron in our requirements gathering phase before we get into policy recommendations. We put some thoughts down on what we need to consider for building, maintaining and sustaining these kinds of directories as a business. We put a few of those ideas down here. One is obviously around what are the essential costs that are necessary. Clearly, there is a cost associated with obtaining and maintaining the content of an ILPD, some sort of cost of maintaining these linkages with the ELPD content, because we would anticipate that these are two different stores of data and that these linkages need to be continuously maintained.

There is the cost specificity of storing and delivering content to the users, so it's the actual sort of application and business rules that would need to be built and maintained, possibly integrated with EHRs or standalone service, however it might instantiated and then cost associated with maintaining polices. These include standards or adjusting customer needs. So if there happen to be errors or there happen to be new policies that are needed in order to assure security, privacy, whatever it happens to be for—the secondary use for example, those are all costs that we've identified as being needed for sustaining and standing up an ILPD to be used for the use cases we've described.

On the revenue side, there are a few different models, obviously, that could be applied. Who is going to be paying for the instantiation and in the maintenance the costs described above? The traditional kinds of revenue models could be for subscription fees that you have access to it and you pay based on some schedule, whether it's a sliding schedule. Or you have some sort of a model that describes the size of the practice or hospital, whatever it happens to be that accesses the ILPDs, whether it's a cost that's formed by a plan, a payer, a provider we've not described here, but we could.

Obviously, there could be user transaction fees where it's a pay for use kind of a scenario. Potentially there are things like grants that could be used. You could—I'm going to skip a little bit into the secondary uses. Actually, it's not about secondary use. It's more about access issues. But can you use an ILPD to identify providers of certain types that might be able to test or enroll patients in protocols, new trials, etc.? So there is definitely potential for grants and research and for public health as well.

Then there are more non-traditional opportunities, where there may be some real economic opportunities here. One is an ILPD potentially can be built to send messages to providers across a network. Again, this could be for new research protocols as they're made, as they're published for clinical trials, as I mentioned, public health alerts. We need to avoid what we typically see in practices today, which is fax

spam, which is a huge volume of information being sent to practices, hospitals, offices where information is not wanted. So there needs to be some control clearly over that so that we're not getting mostly noise over a directory or—

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....

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
At least if the directory did not enable this kind of spamming. The other non-traditional opportunities could be to test and deliver new content and applications, so you could imagine that you could deliver telehealth services by identifying the right providers or using the network for telehealth applications, decision support and mHealth applications and in social networking. You could potentially envision a network, for example—and I'm just making this up—Super Specialists, who want to communicate with other Super Specialists about a unique case that they have and whether or not other clinicians have dealt with this specific case. You could use the ILPD just to communicate with somebody potentially for a second opinion, etc. as appropriate. So those are some of the non-traditional opportunities that we've identified. Again, this is just sort of a first pass. I want to make sure. Have we missed anything, either on the cost side or on the revenue side or other considerations for the business model that we want to include before we get into a set of recommendations at our subsequent meeting?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Jonah, is there an assumption that there is something that sits in the middle of all of this? What is the assumption under the direct model as to who does all of this?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
When you say the direct model, I assume you mean the NHIN direct model?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Yes.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think the assumption is that underneath the ILPD there is some entity that is managing the content and the policies.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Who is that?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
We haven't specifically outlined who that is. I think the assumption, again, is that it would be state HIEs or regional HIEs or HIOs, however you want to define them as a noun. It could be a vendor. It could be a private vendor that is using this. It could be a government. I think the assumption generally is that we're talking more about local, regional or state exchange organizations.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Well, the business model really depends on who is the business, right?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
I mean there are a lot of implications for that and how much duplication there is and how duplication is dealt with and how much exchanging from amongst ILPD managers and ELPD managers there are. I guess in ELPDs we are going to have a certification process, but there is nothing like that for ILPDs, right?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

At this point, we have not considered or we considered and we're not considering making a recommendation around certification of an ILPD or of an entry. The work on ILPDs is part of the greater work on directories, which really, again, coming out of the HIE Workgroup and it's meant to help inform the feds around the right policies and specifically policies for health information exchange organizations, many of which are funded under the ... grants, as you know very well.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Well, yes, but I mean that's where they have the ability to set policy as opposed to being able to tell a private hospital network. I mean it's more difficult to—

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
I mean it's just a different approach, a different model, a different way and all of that has real implications for what we're doing here.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right. Absolutely. So I think that the assumption here is that we're trying to help in some policy around the use of HITECH funds ... funds potentially as well to create directories and the policy levers that are most apparent are meaningful use criteria and EHR certification criteria. I think that's kind of the underlying assumption for most of the work that we're doing, but there's no reason for members of private industry to say we're going to take advantage of this and build a private network and do this better than anybody else and anybody can buy it from us.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Okay. I mean I'm just trying to sort this out. That's all.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. Other thoughts on the business model considerations, costs, revenues, other components? Okay. I think we are coming to the end of our discussion today. If you can move to the next slide we've got a set of next steps. I think the next steps include our HIE Workgroup on January 28th. I think what we'll do is work with the co-chairs of the HIE Workgroup. I don't know what's all in their agenda or if this is the only thing, but we want to review the status of the recommendations. We can make any refinements to, for example, the public health use case, for the discussion today and some of the other discussions we've had over the course of the past month or so on content and operating requirements and business requirements. We may have the opportunity then to go into some real policy recommendations and start the substance of that.

Unless anyone has any other thoughts, I think we're at time and we can open it up to the public.

Judy Sparrow – Office of the National Coordinator – Executive Director
Any other comments? Okay. Operator, could you check and see if anybody from the public wishes to make a comment?

(Operator instructions given)

Judy Sparrow – Office of the National Coordinator – Executive Director
Jonah, I think the next call for this group is February 11th. Is that right?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Kory, is that right?

Kory Mertz – NCSL – Policy Associate
There is one on February 7th.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. We changed that to a ...?

Kory Mertz – NCSL – Policy Associate
Right.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Has a meeting notice gone out for all of the participants?

Kory Mertz – NCSL – Policy Associate
Yes. It just updated. It was an IE Workgroup originally and it just updated it to Provider Directory Task Force.

Operator
We have a comment from the public.

Judy Sparrow – Office of the National Coordinator – Executive Director
Would you please identify yourself and your organization?

Carol Bickford – ANA – Senior Policy Fellow
Carol Bickford, American Nurses' Association. On one of the slides, there is a discussion of the security actions. My question is what interface is there between your workgroup and the bigger security entity? Is there a cross-pollination?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
When you say the security entity, are you talking about the Privacy & Security Tiger Team or—?

Carol Bickford – ANA – Senior Policy Fellow
That would work. I'm sort of at a loss as to understand who all is touching the security pieces in relation to the whole initiative, but it seemed like some of your activities would be redundant for other thought work that's going on.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes, we do have, especially on the HIE Workgroup, which this is a Task Force of, a few members; Paul Egerman, who is a member of this Task Force under the IE Workgroup we've got Deven McGraw. Both of them co-chair the Privacy & Security Tiger Team and that's by design. We wanted to make sure that we have that cross-over just for that level of cross-pollination. In previous, I think you mentioned in the last call; it may have been you; that we need to do a better job of trying to bring in some of the decisions from the last set of calls that we've had. So those who may not have had a chance to listen in on every one, on previous calls we've had discussion around authentication and specifically we had discussion as to whether or not the recommendations really need to come out of this workgroup or the Privacy & Security Tiger Team. I think we ultimately decided that with the consult of those numbers on that team that it should be going over there and the context, by which that discussion has to happen was within the context of a provider directory decision. So we do actually have that cross-over and it's by design; we've tried to build it into the constituencies of the Task Force members.

Carol Bickford – ANA – Senior Policy Fellow
Thank you for the clarification.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
No problem.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Carol. Any other comments?

Operator
No, that is it.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. Thank you. Thank you, Jonah.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Thank you, everybody. We will talk to you if not on Friday, at our next Task Force meeting. Thank you, everyone. Good-bye.

Public Comment Received During the Meeting

1. There has been work done by the CDC for requirements for Public Health Alerts. Have you looked at them?

2. The issues surrounding the linking between HIE "entities, practice locations and practice "entities" and the individual are complicated and critical. Using a couple of specific examples, If a provider is at a specific location of Harvard Vanguard Medical Associates (HVMA), is their entity Harvard Vanguard Medical Associates or their parent organization Atrius Health which has multiple sets of group practice organizations. Similarly should the entity for a physician at Charles River Medical Associates (CRMA) or Partners Community Health Inc (PCHI) where all of the PCHI physicians have access to a common medical record system/results. Does there then also need to be a linking of individuals to practice "groups" to entity used within the HIE as the "gateway" destination?